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CHAPTER V

BILLING INSTRUCTIONS

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CHAPTER V BILLING INSTRUCTIONS

RATES OF REIMBURSEMENT FOR SERVICES FACILITATOR SERVICES

To comply with federal and state mandates, a ceiling for the cost of service coordination services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to geographical locality. The fees for service coordination services vary according to the type of services provided to the individual. The fees must cover all expenses associated with the delivery of service coordination services including nursing visits. The reimbursement rates are considered by the Department of Medical Assistance Services (DMAS) as payment in full for all administrative overhead and other administrative costs that the provider incurs. Service coordination rates are:

<u>Service</u>	<u>Reimbursement Rate</u>
Comprehensive Visit	\$161.00 Rest of State \$209.00 in Northern Virginia
Consumer Training	\$160.00 Rest of State \$208.00 in Northern Virginia
Routine Visit	\$50.00 Rest of State \$65.00 for Northern Virginia
Reassessment Visit	\$80.00 Rest of State \$105.00 Northern Virginia
Management Training	\$20.00 Rest of State \$26.00 Northern Virginia
Criminal Record Check	\$15.00 per Check

The Northern Virginia localities are:

Alexandria City
Fairfax City
Falls Church City
Manassas City
Prince William County
Clarke County
Culpepper County
Fredericksburg City
Warren County

Arlington City
Fairfax County
Loudoun County
Manassas Park City
Fauquier County
King George County
Spotsylvania County
Stafford County

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REIMBURSEMENT RATES FOR PERSONAL ATTENDANT SERVICES

The reimbursement rates for C-DPAS services are as follows:

For Personal Assistance Attendants

	<u>Rates Prior to 7/1/03</u>	<u>Rates Effective 7/1/03</u>
Northern Virginia localities	\$10.00 per hour	\$10.10 per hour
Remainder of Virginia	\$ 7.75 per hour	\$ 7.80 per hour

PATIENT PAY AMOUNT AND COLLECTION

Patient pay is the amount of a Medicaid recipient's income that must be contributed to the cost of his or her care. The amount of patient pay, determined by a Department of Social Services (DSS) eligibility worker, is based on the recipient's income and medically related deductions. It is the responsibility of DSS to notify the recipient and the services facilitator of any change in patient pay amount. Patient pay estimates are obtained by Screening Teams to inform the recipient of the estimated patient pay amount. The services facilitator should immediately initiate a DMAS-122 form and send it to the local DSS upon accepting a referral for service coordination services so DSS can notify the services facilitator of the actual patient pay amounts. The services facilitator should compare these actual figures against the Screening Committee's estimates. If the two do not correspond, the services facilitator should notify the recipient and the Fiscal Agent of the patient pay amount on the DMAS-122.

Upon the receipt of a referral in which a patient pay amount for personal care is indicated, the services facilitator should verify that the recipient understands and agrees to his or her patient pay obligations during the recipient management training. It is not the responsibility of the services facilitator to collect the recipient's patient pay amount. It is the recipient's responsibility to ensure the patient pay amount is given to the personal attendant to cover the amount of personal attendant services authorized.

The recipient's failure to pay the patient pay amount might affect his or her Medicaid eligibility. Therefore, if the services facilitator becomes aware that the recipient is not paying the patient pay amount to the personal attendant, the services facilitator must also notify the local DSS eligibility worker having case responsibility for the recipient. This notification must be in writing and a copy retained in the recipient's record by the services facilitator. It is the consumer-directed (CD) services facilitator's right to decide whether to continue service delivery to a recipient who neglects to remit his or her patient pay to the personal attendant. DMAS will not reimburse the personal attendant for the patient pay amount that is not paid by the recipient.

The patient pay amount is the recipient's contribution toward his or her care received in a calendar month. If the amount of care received in a month by a recipient is less than the patient pay amount, only the cost of the services rendered should be paid by the recipient. If the amount of services rendered is equal to or less than the recipient's patient pay amount, do not bill DMAS for the personal care services provided during that pay period.

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If the amount of services rendered is greater than the amount of the patient pay, the Fiscal Agent will submit an invoice showing the total allowable charges and patient pay amount.

Anytime a new DMAS-122 is received, it is the CD services facilitator's responsibility to note any changes in the amount to be paid by the recipient and to immediately notify the Fiscal Agent. The Fiscal Agent for this program is the Department of Medical Assistance Services (DMAS):

Department of Medical Assistance Services
Fiscal Unit – C-DPAS Program
600 E. Broad Street
Richmond, Virginia 23219
1-866-225-1768 (Phone)
1-804-371-8892 (facsimile) – For General Information and DMAS-122s only.

MEDICAID BILLING INVOICES

Service Coordination Services

The billing invoice for service coordination services is the CMS-1500 (12/90).

SUBMISSION OF BILLING INVOICES

Services facilitators must submit claims using the actual dates of service rendered within a calendar month. Providers may bill for services only once per month. Invoices must include only the allowable charges for the services rendered during the calendar month. Any charges submitted prior to the date authorized by the Screening Committee as the begin date will be denied. The services facilitator must retain the provider copy of the invoice for record keeping. All invoices must be mailed with the proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should be mailed to the address below. Services facilitators should allow at least 30 days for claims processing. The mailing address is:

Department of Medical Assistance Services
Practitioner
PO Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC SUBMISSION OF CLAIMS

Providers may submit claims electronically. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid Claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information, access the First Health website at <http://virginia.fhsc.com> or call 888-829-5373(Option 2) or send email to edivmap@fhsc.com. Correspondence may be directed to the address below:

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EDI Coordinator – Virginia Operations
 FIRST HEALTH Services Corporation
 4300 Cox Road
 Glen Allen, Virginia 23060

ELECTRONIC FILING REQUIREMENTS

(Effective on the date of implementation of the new MMIS.)

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after October 15, 2003, and all local service codes will be ended for claims with dates of service after October 15, 2003. All claims submitted with dates of service after October 15, 2003 will be denied if local codes are used.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of profession claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims. If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <http://virginia.fhsc.com>.

TIMELY FILING OF THE CMS-1500 (12-90) FOR SERVICE COORDINATION SERVICES

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the date of the last date of service or discharge. Federal financial participation is not available for claims that are not submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers of the 837 transaction for attachments. See exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

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- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.
- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. Providers who have rendered services for a period of delayed eligibility will be notified by a copy of a letter from the local DSS which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The services facilitator must submit a claim on the appropriate Medicaid claim form within 12 months from the date of receipt of the notification of the delayed eligibility. A copy of the dated letter from the local DSS indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Denied Claims** - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:
 - Complete the CMS-1500 (12-90) invoice as explained under "Instructions for the Use of the CMS-1500 (12-90) Billing Form" elsewhere in this chapter.
 - Attach written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and timely filing must be waived, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers of the 837 transaction for attachments. See exhibits)
 - Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form. The DMAS-3 is to be used by electronic billers of the 837 transaction to submit attachments.
 - Submit the claim as usual by mailing the claim to:

Department of Medical Assistance Services
Practitioner

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Post Office Box 27444
Richmond, Virginia 23261-7444

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.
- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

PRE-AUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring pre-authorization, all pre-authorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, WVMI will perform after-the-fact authorizations.

TURNAROUND DOCUMENT LETTER (TAD)

(Effective on the date of implementation of the new MMIS.)

Upon implementation of the new MMIS, if lines on an invoice were completed improperly, a computer-generated letter is sent to the provider to correct the error (the TAD). The TAD should be returned to FHS or the claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

PATIENT INFORMATION FORM (DMAS-122)

Purpose

The local DSS office and a personal attendant care provider use this form to exchange information with respect to:

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- The responsibility of an eligible recipient to make payment toward the cost of care;
- The admission, discharge, or death of the recipient; and
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The provider shall prepare the form to request a Medicaid number, eligibility determination, or confirmation of patient pay or to notify the local DSS of changes in the enrollee's circumstances. The local DSS must prepare a new form at the time of each re-determination of eligibility and whenever there is any change in the enrollee's circumstances that results in a change in the amount of the patient pay.

Disposition of Copies

The provider should initiate the form upon receiving a referral from the Nursing Home Pre-Admission Screening Team (NHPAST) in order to notify the local DSS that he or she has accepted the enrollee as a client/patient, and to provide the beginning date of service. Upon the determination of eligibility, the DMAS-122 will be returned to the provider with the following information:

- Whether the enrollee does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient pay responsibility begins.

There must be a completed DMAS-122 form in the recipient's file prior to billing DMAS. The provider must also provide a copy of the DMAS-122 to the Fiscal Agent.

REPLENISHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

The CMS-1500 (12-90) claim form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS web site (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select

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“provider” to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

INQUIRIES CONCERNING BILLING PROCEDURES

For inquiries concerning covered benefits, specific billing procedures, or remittances contact the Medicaid HELPLINE at:

1-804-786-6273
1-800-552-8627

Richmond Area and out-of-state
In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pending, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location which contains the provider’s name and current mailing address as shown in the DMAS’ provider enrollment file. In the event of a change-of-address, the U.S. Postal Service will not forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS’ Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for these special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

(Effective on the date of implementation of the new MMIS.)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set will be used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is

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electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health, at 888-829-5373, and choose option 2 (EDI).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Division of Program Support
Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers
1-804-786-6273 Richmond Area and out-of-state
1-800-552-8627 In-state long distance (toll-free)

Enrollee verification may be obtained by telephoning:

1-800-884-9730 Toll-free throughout the United States
1-804-965-9732 Richmond and Surrounding Counties
1-804-965-9733 Richmond and Surrounding Counties

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INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILLING FORM FOR SERVICE COORDINATION SERVICES

To bill for services, use the Health Insurance Claim Form, CMS-1500 (12-90), invoice form. The following instructions have numbered items corresponding to fields on the CMS-1500. The fields required to be completed are printed in boldface type. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information, and provider-specific instructions are found on page 20. (See the “Exhibits” section at the end of this chapter for a sample of this form.)

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90) Billing Invoice

The purpose of the CMS-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed CMS-1500 claim form follows the instructions for its use.)

<u>Locator</u>		<u>Instructions</u>
1	REQUIRED	Enter an “X” in the MEDICAID box.
1a	REQUIRED	<u>Insured’s I.D. Number</u> —Enter the 12-digit Virginia Medicaid Identification number for the enrollee receiving the service.
2	REQUIRED	<u>Patient’s Name</u> —Enter the name of the enrollee receiving the service.
3	NOT REQUIRED	<u>Patient’s Birth Date</u>
4	NOT REQUIRED	<u>Insured’s Name</u>
5	NOT REQUIRED	<u>Patient’s Address</u>
6	NOT REQUIRED	<u>Patient Relationship to Insured</u>
7	NOT REQUIRED	<u>Insured’s Address</u>
8	NOT REQUIRED	<u>Patient Status</u>
9	NOT REQUIRED	<u>Other Insured’s Name</u>
9a	NOT REQUIRED	<u>Other Insured’s Policy or Group Number</u>
9b	NOT REQUIRED	<u>Other Insured’s Date of Birth and Sex</u>
9c	NOT REQUIRED	<u>Employer’s Name or School Name</u>

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- 9d NOT REQUIRED Insurance Plan Name or Program Name
- 10 REQUIRED **Is Patient's Condition Related To: —Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.)**
a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)
- 10d CONDITIONAL **Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
- 11 NOT REQUIRED Insured's Policy Number or FECA Number
- 11a NOT REQUIRED Insured's Date of Birth
- 11b NOT REQUIRED Employer's Name or School Name
- 11c NOT REQUIRED Insurance Plan or Program Name
- 11d NOT REQUIRED Is There Another Health Benefit Plan?
- 12 NOT REQUIRED Patient's or Authorized Person's Signature
- 13 NOT REQUIRED Insured's or Authorized Person's Signature
- 14 NOT REQUIRED Date of Current Illness, Injury, or Pregnancy
- 15 NOT REQUIRED If Patient Has Had Same or Similar Illness
- 16 NOT REQUIRED Dates Patient Unable to Work in Current Occupation
- 17 CONDITIONAL **Name of Referring Physician or Other Source**
- 17a CONDITIONAL **I.D. Number of Referring Physician —Enter the Virginia Medicaid provider number of the referring physician. See the following pages for special instructions for Service Coordination Services for Consumer-Directed Services.**
- 18 NOT REQUIRED Hospitalization Dates Related to Current Services
- 19 NOT REQUIRED Reserved for Local Use
- 20 NOT REQUIRED Outside Lab?

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- 21 REQUIRED** Diagnosis or Nature of Illness or Injury —Enter the appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.
- 22 CONDITIONAL** Medicaid Resubmission —Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
- 23 REQUIRED** Prior Authorization Number —Enter the assigned prior authorization number for the services (if applicable).
- 24A REQUIRED** Dates of Service —Enter the from and thru dates in a two-digit format for the month, day, and year (e.g., 04/01/98). THE DATES MUST BE WITHIN THE SAME CALENDAR MONTH.
- 24B REQUIRED** Place of Service —Enter the two-digit CMS code which describes where the services were rendered. Enter “12” in this field (Patient’s Home).
- 24C REQUIRED** Type of Service —Enter the one-digit CMS code for the type of service rendered. Enter “1” in this field (Medical Care).
- 24D REQUIRED** Procedures, Services or Supplies —See pages following the instructions for special billing instructions.
- CPT/HCPCS—Enter the five character CPT/HCPCS Code which describes the procedure rendered or the service provided. See the attached code list for special instructions is appropriate for the service provided.
- Modifier—Enter the appropriate HCPCS/CPT modifiers if applicable.
NOTE: Use modifier “22” for individual consideration. Claims will pend for manual review of the attached documentation.
- 24E NOT REQUIRED** Diagnosis Code —Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.
- 24F REQUIRED** Charges —Enter the total usual and customary charges for the procedure/services. See the special

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instructions following these instructions if applicable for the service provided.

24G REQUIRED

Days or Units —Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to the service provided.

24H CONDITIONAL

EPSDT or Family Plan —Enter the appropriate indicator. Required only for EPSDT or family planning services.

1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services

2 - Family Planning Services

24I CONDITIONAL

EMG (Emergency) —Place a “1” in this block if the services are emergency-related. Leave blank if not an emergency.

24J REQUIRED

COB (Primary Carrier Information) —Enter the appropriate code.

2 - No Other Carrier

3 - Billed and Paid (use for patient pay)

5 - Billed, No Coverage

24K REQUIRED

Reserved for Local Use —Enter the dollar amount received from the primary carrier or the patient pay amount if Block 24J is coded “3.”

25 NOT REQUIRED

Federal Tax I.D. Number

26 OPTIONAL

Patient's Account Number —Up to Seventeen alpha-numeric characters are acceptable.

27 NOT REQUIRED

Accept Assignment

28 NOT REQUIRED

Total Charge

29 NOT REQUIRED

Amount Paid

30 NOT REQUIRED

Balance Due

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- 31 **REQUIRED** Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.
- 32 NOT REQUIRED Name and Address of Facility Where Services Were Rendered
- 33 **REQUIRED** Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in the Virginia Medicaid provider record. Enter the Virginia Medicaid servicing provider number in the PIN # field and the billing provider number, if applicable, in the GRP# field. Ensure that the provider numbers are distinct and separate from the phone number or ZIP Code.

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Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code —Enter the three- or four-digit code (as applicable) identifying the reason for the submission of the adjustment invoice.

OLD CODE ¹	NEW CODE ¹	DESCRIPTION
523	1023	Primary Carrier has made additional payment
524	1024	Primary Carrier has denied payment
526	1026	Patient payment amount changed
527	1027	Correcting service periods
528	1028	Correcting procedure/service code
530	1030	Correcting charges
531	1031	Correcting units/visits/studies/procedures
532	1032	IC reconsideration of allowance, documented
----	1053	Adjustment reason is miscellaneous category

Original Reference Number —Enter the claim reference/ICN number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

¹ Providers may begin using the new codes once the new MMIS is implemented.

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Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code —Enter the three- or four-digit code (as applicable) identifying the reason for the submission of the void invoice.

OLD CODE ²	NEW CODE ²	DESCRIPTION
542	1042	Original claim has multiple incorrect items
544	1044	Wrong provider identification number
545	1045	Wrong recipient eligibility number
546	1046	Primary carrier has paid DMAS maximum allowance
547	1047	Duplicate payment was made
548	1048	Primary carrier has paid full charge
551	1051	Recipient not my patient
552	1052	Void is for miscellaneous reasons
560	1060	Other insurance is available

Original Reference Number —Enter the claim reference/ICN number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

² Providers may begin using the new codes once the new MMIS is implemented.

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SPECIAL BILLING INSTRUCTIONS -
Service Coordination Services for Consumer-Directed Services

Locator 24D Procedures, Services or Supplies

It is essential that the provider submit all claims in a timely manner, preferably within 30 days of the date that the service was provided.

CPT/HCPS - Enter the appropriate procedure code from the following list.

LOCAL CODE ³	NEW NATIONAL CODE ³	MODIFIER	DESCRIPTION
Z9560	H2000		Comprehensive Visit
Z9566	S9122		Consumer Training
Z9562	99509		Routine Visit
Z9564	T1028		Reassessment Visit
Z9568	S5116		Management Training
Z9570	99199	U1	Criminal Record Check
Y0078	S5126		Attendant Care
Z8811	99080		Fiscal Administrative Costs (DMAS ONLY)
Z9590	G9002		CDPAS Weekly Services (DMAS ONLY)

³ Providers may begin using the national billing codes for dates of service on or after June 20, 2003. For dates of service after October 15, 2003, national billing codes must be used. A local/national code crosswalk is available on the DMAS website.

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EXHIBITS

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VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

--	--	--	--	--

**Patient Account Number (20 positions limit)*
Number (5 digits)**

M M D D C C Y Y Sequence

Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	Provider Name:
-----------------------------	---------------------------

Enrollee Identification Number:
--

Enrollee Last Name:	First:	MI:
--------------------------------	---------------	------------

<input type="checkbox"/> Paper Attached	<input type="checkbox"/> Photo(s) Attached	<input type="checkbox"/> X-Ray(s) Attached
<input type="checkbox"/> Other (specify) _____		

COMMENTS: _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.)

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.
2. **Date of Service** – Enter the from date of service the attachment applies to.
3. **Sequence Number** – Enter the provider generated sequence number up to 5 digits only.
4. **Provider Number** – Enter the Medicaid Provider number.
5. **Provider Name** – Enter the name of the Provider.
6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.
7. **Enrollee Last Name** - Enter the last name of the Enrollee.
8. **First** – Enter the first name of the Enrollee.
9. **MI** – Enter the middle initial of the Enrollee.
10. **Type of Attachment** – Check the type of attachment or specify.
11. **Comment** – Enter comments if necessary.
12. **Authorized Signature** – Signature of the Provider or authorized Agent.
13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)				
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: DATE:					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED:				
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
1. _____ 3. _____ 2. _____ 4. _____					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES				
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					28. TOTAL CHARGE \$				
29. AMOUNT PAID \$					30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: DATE:					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					PIN# GRP#				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PHYSICIAN OR SUPPLIER INFORMATION